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MENTAL HEALTH CARE—CAN THE USAF DO MORE TO ENCOURAGE HELP SEEKING BEHAVIOR?

by

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The purpose of this research paper is to demonstrate how the USAF can take additional steps to de-stigmatize mental health treatment, and encourage help seeking behavior among its active duty members. Its aim is to spread awareness of current mental health issues, and to offer some solutions in coping with issues involved with seeking help for mental health care. This paper discusses the stigma surrounding mental health care within society and the military. The review of issues concentrates on generic and historic sources of mental health topics, as well several primary military resources. It presents a thorough and balanced look at the current issues impacting mental health, and what has caused these issues to remain. The research then examines the initiatives the USAF has recently undertaken to address these issues. It suggests the military is not immune from the problems associated with seeking help for mental health care, and though the USAF has recognized the problems, its efforts, up until now, have not been entirely successful at de-stigmatizing the use of military care facilities for mental health care. Finally, the research suggests ways the USAF could further alleviate the problems in the future, and encourage more help seeking behavior among its members.

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Contents

Page

DISCLAIMER ii

LIST OF ILLUSTRATIONS iv

PREFACE v

ABSTRACT vi

INTRODUCTION 1

REVIEW OF THE RELATED ISSUES 4
- Scope of Mental Illness 4
- Impact of Mental Illness 5
- Suicide 5
- Stress and Mental Health 6
- Need for Mental Health Care in the Military 8
- The Mental Health Stigma 9
- Confidentiality and Career Impact 10
- Studies in Military Medicine 12
- Summary 14

MENTAL HEALTH CARE INITIATIVES IN THE USAF 19
- Relevant USAF History 19
- Integrated Product Team Initiatives 20
- Confidentiality 23

RECOMMENDATIONS 26

CONCLUSION 35

GLOSSARY 37

BIBLIOGRAPHY 38

Illustrations

Page

Figure 1. Potential Outcome of Mismanaged Stress..... 8

Preface

Our society continues placing a stigma on those people that need mental health care. The military is not immune from this stigma. Many in the military still believe seeking help for mental health problems is related to some sort of mental deficiency, or that it is a sign of weakness. Still others have concerns about confidentiality or the impact seeking help may have on their careers. For these people, seeking help may not even be an option. In these days of dwindling defense budgets and shrinking numbers of personnel, military leaders can ill afford to lose anyone to a preventable or treatable medical condition. A commander's ignorance of mental health issues could seriously jeopardize the successful mission accomplishment of a military organization. In the past few years, the USAF has taken note of these problems, and has come up with several new initiatives and alleviating steps. I believe these current initiatives, are a big step forward, and I offer further recommendations to encourage help seeking behavior.

I'd like to acknowledge, and thank, Maj. Marlin Moore, Chief, ACSC Wellness Program, for the assistance and guidance he gave me as my Faculty Research Advisor on this research project.

Abstract

The purpose of this research paper is to demonstrate how the USAF can take additional steps to de-stigmatize mental health treatment, and encourage help seeking behavior among its active duty members. Its aim is to spread awareness of current mental health issues, and to offer some solutions in coping with issues involved with seeking help for mental health care. This paper discusses the stigma surrounding mental health care within society and the military. The review of issues concentrates on generic and historic sources of mental health topics, as well several primary military resources. It presents a thorough and balanced look at the current issues impacting mental health, and what has caused these issues to remain. The research then examines the initiatives the USAF has recently undertaken to address these issues. It suggests the military is not immune from the problems associated with seeking help for mental health care, and though the USAF has recognized the problems, its efforts, up until now, have not been entirely successful at de-stigmatizing the use of military care facilities for mental health care. Finally, the research suggests ways the USAF could further alleviate the problems in the future, and encourage more help seeking behavior among its members.

Chapter 1

Introduction

> *I believe very strongly that leadership has a responsibility to get their people the resources to do their job.*
>
> *I look at [mental health help] as another tool that's available…we should not make tools available for people to use then punish them when they use them, or put some stigma on them.*
>
> —General Ronald Fogleman, Former Air Force Chief of Staff

In these days of dwindling defense budgets and shrinking numbers of personnel military leaders can ill afford to lose anyone to a preventable or treatable medical condition. A commander's ignorance of mental health issues could seriously jeopardize the successful mission accomplishment of a military organization. This research paper focuses on enhancing the awareness level of mental health issues in the minds of the "non-medical" military professionals. The Thesis Statement is: the USAF can take additional steps in dealing with mental health treatment issues and encourage more help seeking behavior among the active-duty force. This research first looks at the related issues that impact help seeking behavior among USAF active-duty member. It then examines what the USAF has done and is currently doing related to these matters. Finally, the research will give some recommendations on how the USAF could encourage more help seeking behavior among its active-duty members.

So why should the USAF military leader care about mental health issues? First, mental illnesses are much more common than one may think. According to an estimate from the National Institute of Mental Health (NIMH), "…22 percent of Americans eighteen and older suffer from some type of mental disorder in any given year."[1] Second, although mental illnesses cover a broad scope, "…most major illnesses are extremely treatable."[2] Third, the cost of mental illness is enormous. In 1990, it was estimated "…the total cost of all mental [illnesses] in America was almost $148 billion."[3] The military is by no means immune to these costs. These costs can and do show up as absenteeism, loss in productivity, loss of enthusiasm, and some times loss of life. Fourth, the USAF has taken notice of the problems arising from mental illnesses, and in the past two years has researched and developed several new initiatives that will impact every member of the USAF.[4] Fifth, not only are military leaders responsible for being educated and responsible for taking care of their own health, they are also responsible for the well being of the people who work for them. The issues associated with seeking mental health care pose big problems in both society and the military. Though all military personnel have regular medical physicals, these problems may be amplified in the USAF because of the preponderance of aircrew members employed. These aircrew members require more frequent and more stringent medical physicals than their non-flying counterparts in order to perform their duties. This increased emphasis on one's "flight" physical, or fitness to fly, only exaggerates the issues that prevent members from seeking out help. It is quite conceivable an unhealthy environment persists within the USAF, and that at any given time, there are USAF members conducting their duties while trying to deal with a mental

health problem on their own. The previous matters are just a view of the reasons why USAF leaders should be concerned about the issues involved around mental health care.

Notes

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Chapter 2

Review of the Related Issues

Scope of Mental Illness

According to some estimates, at any given time 10-15% of the American population have mental health problems sufficient enough to warrant professional care; but only 3-5% of the American population are receiving mental health treatment at any one time.[1] This leaves the vast majority of those people living without the help they need. Victor Reus, M.D., a professor of psychiatry at the University of California at San Francisco School of Medicine, estimates 80% of the people currently suffering from a mental illness do not get treatment.[2] There are numerous types of mental disorders and they afflict the American populations at different rates. Depression is, by far, the most common type of mental illness.[3] In fact, according to Deborah Stephens, chief executive of Behavioral Health Systems, "On average, every single person during their lifetime will go through an episode of depression."[4] Since the military selects its personnel from the American population, it is reasonable to assume similar occurrence rates exist within the military population.

Impact of Mental Illness

In 1978, the President's Commission on Mental Health surveyed the nation's mental health needs, and cited estimates of the cost of mental illness in the US alone as being about $17 billion per year.[5] More recent surveys have isolated depressive illness' impact, and it is estimated that depression, alone, costs the US $43.7 billion per year.[6] Depression can have a negative affect on morale and absentee rates. It also has the potential to reduce work quality and the enthusiasm of a worker. Not only can an individual's work performance be affected, but left untreated, a mental illness can eventually lead to, and has led to, suicide.[7] Regardless of the type of mental illness suffered, these illnesses, and their impact, should be taken seriously. According to psychiatrist Harvey L. Ruben, major depression is the leading cause of suicide in the US. He believes, "…15% of those suffering from major depression will commit suicide."[8] But it is not limited to those with a history of depression. Ruben also suggests, "…a crisis in a person's life can also lead to suicide in certain people."[9]

Suicide

Suicide is the ninth leading cause of death in the US.[10] There are roughly 30,000 US suicides, and an estimated over 100,000 attempted suicides annually.[11] There also exists a definite gender gap. However, the most recent suicide trends, developed by the Centers for Disease Control, suggests that suicide rates among women are declining while the male rate is on the increase.[12] Some experts believe one primary factor impacting the difference in suicide rates seen between the genders centers around a females' willingness to seek help. Women more readily seek treatment, and this has decreased their suicide rates. Men, on the other hand, generally still view, "…seeking treatment for

mental illness as a weakness."[13] Men tend, "…not [to] view communicating their feelings as [an option], so they get more depressed and hopeless [which leads to suicide]."[14]

In the US, the suicide rate per 100,000 persons has remained a constant 12.4 during this century. However, as the population has increased so has the number of suicides.[15] Within the Department of Defense's active duty force, there were 2,654 suicides from January 1983 through December 1993. The 723 suicides in the Air Force during this same period included members from all ranks, both male and female.[16] In recent years, a number of tragic suicides within the military have brought this problem to the surface, and made mental health care a priority issue for some concerned USAF leaders. Currently, "…suicide is the second leading cause of active-duty deaths."[17] Investigators showed a number of risk factors were present in the 48 suicides the USAF experienced in 1996: "…19 had job-related problems, 17 were depressed, 12 had financial problems and 12 had multiple risk factors."[18] The USAF investigators disclosed that some of the suicide victims were triggered by "stress-provoking situations."[19]

Stress and Mental Health

As the above discussion on suicide suggests, stress plays a major role in the mental health problems facing contemporary society. In fact, it has reached "pandemic proportions."[20] "It has been estimated that two-thirds of the visits to family physicians are prompted by stress related symptoms."[21] Many scholars have written on the subject of stress. In the book, *Stress and Health*, Phillip Rice also suggests, "personal crisis, of shattering proportions exceeding a person's ability to cope, cause thousands of people to seek professional help for emotional distress annually."[22] Hughes, Ginnet, and Curphy,

in their book, *Leadership-Enhancing the Lessons of Experience*, state the following about stress, and managing stress:

> …too much stress can take its toll on individuals and on their organizations. For individuals, the toll can be in terms of their health, mental and emotional well-being, job-performance, or interpersonal relationships. For organizations, the toll includes decreased productivity, and increased employee absenteeism, turnover, and medical costs. It stands to reason, then, that leaders in any activity should know something about stress. Leaders should understand the nature of stress because the leadership role itself can be stressful and because leaders' stress can impair the performance and well-being of followers.[23]

Further evidence of the impact of stress is revealed by Walt Schafer's book, *Stress Management for Wellness*. Schaefer talks about two kinds of stress. Positive stress, which is, "…arousal that contributes to health satisfaction, and productivity," and a negative stress, which Schafer terms "distress", which is, "…too much or too little arousal resulting in harm to [the] body or mind."[24] He points out the severe costs resulting from distress. Not only does distress cause problems in an individual, but it has a "ripple-effect" outward upon the community the individual lives and works in.[25] If mismanaged, stress can and does lead to all kinds of problems including death. See Figure 1.[26]

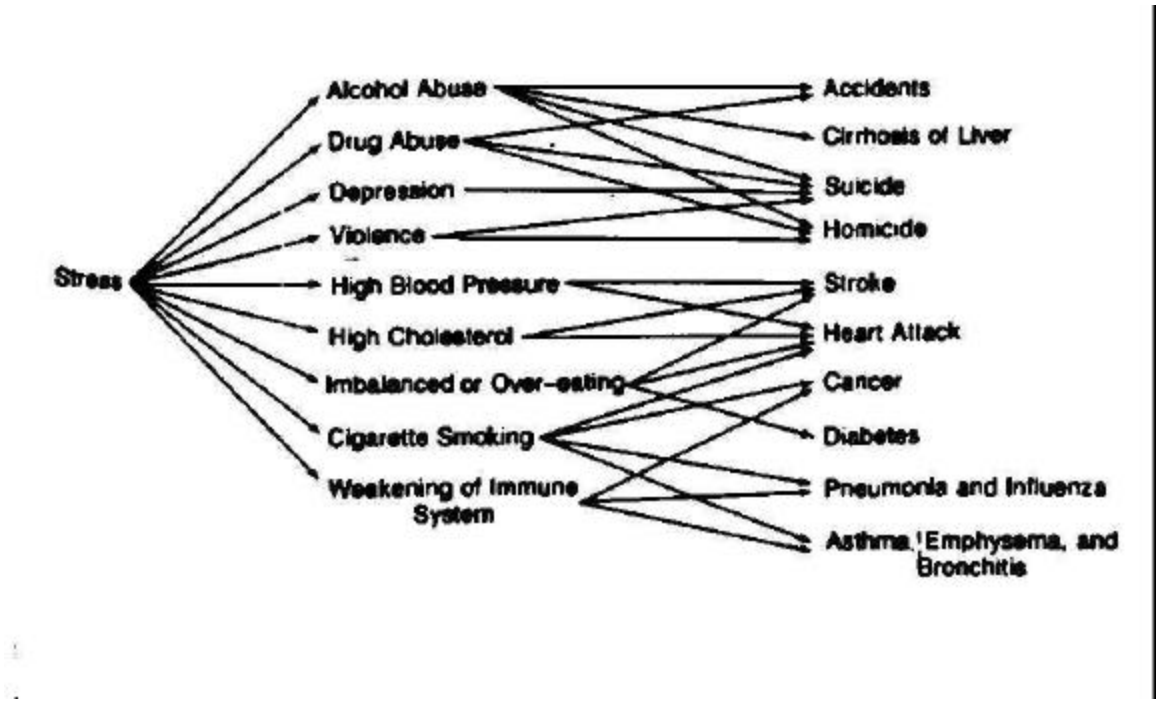

Figure 1. Potential Outcome of Mismanaged Stress

Stress also has its impact on military members. Former Air Force, chief of staff, General Ronald R. Fogleman acknowledged that the pressure of being a top performer in a smaller military could create a climate in the Air Force that is conducive for the kinds of stresses that can lead to mental health problems. He affirmed that the pressure on military people could be enormous, and that at some point these pressure could catch up with even the strongest of people.[27]

Need for Mental Health Care in the Military

Mental health care is recognized as an essential part of a military member's medical needs and therefore a comprehensive program is provide to all those who are eligible for military medical coverage. General Fogleman viewed the use of mental health as another tool available for Air Force people to use. He long recognized that the mental health of the troops was as important as their physical well-being.[28] Fogleman said:

> seeking help does not mean that someone is [necessarily] unfit for promotion or for a leadership position. In fact the opposite approach would be more appropriate. Without help, you're going to have trouble being fit for promotion , you're going to have trouble doing your job. You're going to have trouble performing in the fashion that we expect you to perform if you have some form of mental illness or stress or strain that's at work on you. So I would encourage people to go seek out the help that they need to get well.[29]

Another top USAF official, Lieutenant General Charles H. Roadman, II, USAF Surgeon General, stated "…the USAF is working hard to de-stigmatize mental health care through two means: policy changes and public affairs initiatives."[30]

The Mental Health Stigma

The stigma attached to mental illnesses is not a recent phenomenon. From the early parts of recorded history mental deviations were attributed to supernatural or unnatural causes, the work of evil spirits, or human depravity.[31] Historical literature is filled with horrifying accounts of the inhumane treatment mentally ill persons encountered. Though the days of living in jails, poorhouses, and insane asylums, and the use of barbaric medical treatment, has long since ended, a stigma still clings to those having a mental illness and the fear of this stigma prevents many from seeking care.[32]

Many factors influence the existence of the mental illness stigma. According to Gerald Quimby, National Certified Counselor, "There are millions of people throughout the country keeping themselves from seeking [medical] help because of the perception that mental illness is something that should be kept secret."[33] Others believe there is, "so much shame surrounding mental illness that many people wait until they break down completely before getting help."[34] For years many mental health professional have been trying to erase the stigma associated with mental illnesses through education efforts about

the true nature of various disorders. Though education efforts are critically important, they have not been successful at eradicating this perception from society.[35]

These perceptions from society are, in-turn, carried over into military communities. General Fogleman stated, "…the stigma applied to people who seek mental health treatment is from another era and those who seek treatment should not be considered weak."[36] It is not necessarily just the stigma that keeps active-duty member from seeking care from mental health, but military members may have added concerns about confidentiality and the potential impact to their career. Lt. General Roadman acknowledged this, stating, "…he believed the USAF's current approach of lowering barriers to mental health care holds promises, but, perhaps the greatest barrier to active duty members seeking mental health care is the lack of confidentiality."[37]

Confidentiality and Career Impact

According to former Congresswoman Patricia Schroeder, "…confidentiality [between a patient and a psychotherapist] is widely understood to be essential for successful treatment of mental [and] emotional problems…" [38] According to her, military members, their families, and even retirees give up this privilege when they obtain mental health care from a military medical facility. She believes people eligible for military health care fail to seek needed treatment because their privacy is not guaranteed.[39] On the other hand, Colonel Robert E. Reed, Chief of the Military Justice Division in the Air Force Judge Advocate General's office at the Pentagon, claims Air Force medical records are protected by the Federal Privacy Act, but concedes there is an inaccurate perception that the Air Force does not respect the confidentiality of these records.[40] According to Reed, this act "…generally prohibits the release of the records…without the patient's

permission…[but he adds]…the act does authorize the use of the records…for limited and official Air Force purposes."[41]

General Fogleman admitted the perception still exists, within the military, that turning to mental health for help is automatically a career-ending move.[42] Lt. General Roadman also confirmed his believe that many in the military hold on to this erroneous perception from the past. In responding to the author's questions in researching this paper, Lt. General Roadman concluded his response letter by stating, "[he] wanted to ensure Air Force members that voluntarily seeking mental health care will not necessarily be the career-ending move many perceived it to be in the past."[43]

According to Maj. Marlin K. Moore, Chief, ACSC Wellness Program, and a clinical psychologist, the crux of the confidentiality issue is in balancing national interests, or the needs of the USAF, against the needs of the individual who may hold a high security clearance, fly, or work with nuclear weapons. These are often in conflict with one another. When they join the DOD, military members accept limited rights to total confidentiality and privileged communications, and are informed of this prior to seeking treatment. For example, both the member, and the medical professionals who treat the members, are required by Air Force Instruction (AFI) to inform the member's commander when an active duty member who works around nuclear weapons is unable to perform his other duties. After the condition is resolved, the member can be re-evaluated and returned to duty.[44]

Unfortunately, the way directives were written, and carried out in the past, led to some abuses denying members a level of confidentiality they should have been entitled to.[45] The fallout from these documented cases is, quite possibly, still influencing active-

duty members' willingness to seek help from military mental health care providers. Active-duty members may be neglecting needed treatment for a mental health problem because they perceive it will automatically have a negative impact on their career, or their concerns for privacy prevent them from seeking help because they do not enjoy total confidentiality, or privileged communications with the military care provider. The following studies in military medicine further discuss the issues and causes involved.

Studies in Military Medicine

Relevant findings from some studies published from 1992-1994 are summarized in the following paragraphs.

One of these studies suggested military members did not seek help for a mental illness because they did not know where to go for help, or they were afraid to ask for help, because they were afraid of the diagnosis.[46] This study pointed to a possible lack of education and a general unawareness about mental health care issues among the military members represented in the study. This study, comparing self-referred and supervisor-referred clients, suggested that those waiting for things to get bad enough for their supervisor to step in and take action, were more frequently returned to duty, "…*with* job limitations compared to those members who self-initiated their own help."[47] In fact, the study found, "…only 3% of the self-referred group was given some recommendations for limits." [48] Though the difference in job limitations between the two groups can not necessarily be related to how they were referred (i.e., it may be due to difference in disturbance severity level experienced by each group. That is, those who self-referred may have been slightly to moderately disturbed compared to those supervisor-referred who may have been severely disturbed.), this study did show that patients who self-refer

need not have "undue fear of losing their jobs." [49] Seeking help was not automatically a career-ending move.

A second study, comparing demographics and referral patterns, also revealed pertinent information. This study found that older and married military members were more likely to self-refer themselves for mental health care than the younger, and single members.[50] Likewise, "…a military member without a special duty status was more likely to self-refer than a member with a security clearance or weapons-bearing status."[51] This former result was attributed to the maturity of the member, and therefore, an educational factor, or the positive influence a spouse could have in encouraging help seeking behavior. The latter result indicated a member's willingness may depend on his or her duty specialty, and whether or not there is an enhanced fear of losing one's job based upon the special nature of a member's duty. These results may suggest that those without a special duty have more mental health problems than those with a special duty, therefore, they seek help more often. But these results could also suggest, that active-duty members holding special duty positions perceive a greater impact to their careers, and thereby avoid seeking out help. The author suggests the latter result is more convincing.

A third study acknowledged there was potential where seeking mental health care could adversely impact a person's career.[52] Members could be discharged for rare conditions, or at least temporarily removed from duty. This study acknowledged, "…the fear of impact to one's career had not been quantified among military personnel…", but it also indicated this fear was not uncommon. Military mental health providers had routinely encountered members who had avoided treatment, sought civilian care, or even

admitted removing documents from their medical record in order to eliminate any potential negative career impact.[53] The results of this study reflected the concerns of the member are justified only in rare instances. It appeared highly unlikely that a member's career would be ended simply by receiving mental health care.[54]

A final military study looked at legal and ethical issues faced by a military psychologists. This study revealed Department of Defense (DOD) directives regarding patient confidentiality conflict with standards of the American Psychological Association.[55] This study pointed out that many service members give up their right to privacy for themselves and their families, by their participation in nuclear, or other sensitive or classified duties. It stated, "…confidentiality does not exist for these persons," and acknowledged this could account for this groups' low utilization of mental health services[56].

Summary

There are many reasons people on active-duty avoid needed mental health care. It could be the stigma around mental illness creates the fear, or it could be the fear of career impact, and concerns over confidentiality prevent active-duty members from seeking help. It may be impossible to ever isolate which issues have the most influence and how each issue impacts the other. Isolating the impact of each issue may not really be important. What is *more* important is these issues are recognized as significant factors, and that military leaders can and do have some influence at encouraging help seeking behavior.

The military studies reviewed in this chapter highlighted some relevant aspects of military mental health care. Combined, these studies address issues, conditions and

potential causes that influence the mental health stigma and impact a member's willingness to seek help. Specifically, these studies show the stigma does exist but it may not be the stigma that primarily influences an active-duty member's willingness to seek help from a military mental health care facility. Concerns over confidentiality and how seeking help may impact one's career are the real issues that come out from these studies. Another issue that comes out is a member's willingness may depend heavily on his or her duty specialty, and whether or not there is an enhanced fear of losing one's job based upon the special nature of a member's duty. This issue, in particular, should catch the attention of all military leaders. The military members with special duty status (i.e., those on the Personnel Reliability Program [PRP status], flying status, weapons-bearing personnel, or with sensitive security clearances) were less likely to seek help. It is these members, with a special duty, that are typically at the "tip of the spear", that is, they conduct operations. It should be of extreme concern to all military leaders that those people holding special duty status receive all the health care they need.

Though the previous studies discussed involved mental health issues, these same concerns and issues may discourage active-duty members from seeking help from all types of military medical care, not just mental health care. However, top USAF leaders have identified this as a particular issue impacting mental health care, and thus this research is focused on encouraging help seeking behavior for mental health care. The collective sum of these studies equate to there being a stigma around mental health care in the military. The stigma is largely unwarranted, that is, it is not an automatic career breaker. In very few cases will seeking help from mental health care jeopardize one's

career. The stigma persists quite possibly because of lack of education among military members, and the member's continued concerns over confidentiality and career impact.

Society at large, and the USAF community have made great strides in administering mental health care over the recent past. So what is being done? The next chapter will address some of the recent initiatives society and the USAF have done to address the issues and causes raised in this chapter.

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[50] Capt. Anderson B. Rowan, "Demographic, Clinical, and Military Factors Related to Military Mental Health Referral Patterns," *Military Medicine*, no. 161, June, 1996, 324-26.

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[52] LCDR Taylor L. Porter, MC USNR, and LT W. Brad Johnson, "Psychiatric Stigma in the Military," *Military Medicine*, no. 159, September, 1994, 602-605.

[53] Ibid.

[54] Ibid.

[55] Timothy B Jefferey,., Louise K. Jefferey, and Robert J. Rankin, "In Service of Two Masters: The Ethical Dilemma Faced by Military Psychologists," *Professional Psychology: Research and Practice*, no. 23-2, 1992, 91-92.

[56] Ibid.

Chapter 3

Mental Health Care Initiatives in the USAF

Relevant USAF History

In 1993, General Fogleman recognized the connection between mental illness and suicides and took some action. Then, as Commander of Air Mobility Command, General Fogleman developed a program called Ready Eagle, which was to be an umbrella program using a variety of tools to help people cope with the myriad of changes and stresses of life in the military.[1] In June 1996, following a series of tragic, and publicized military suicides, General Fogleman, as the USAF's Chief of Staff, directed an Air Force-level Integrated Product Team (IPT) to review suicide in the USAF. This team, led by Lt. General Roadman, came up with 11 recommendations.[2] Some of these recommendations have now been implemented, while others are still under study. Though the programs the IPT recommended and implemented are targeted at suicide prevention, the issues involved are directly related to the much broader field of mental health care, and the stigma attached to those who seek out help in general. Not only will the recommendations of the IPT have an impact on suicide prevention, they should also have a positive impact on mental health issues overall.

Integrated Product Team Initiatives

The recommendations of the IPT were released in February of 1997.[3] It is not the intent of this research to analyze each of the eleven recommendations in detail (see endnote source for further details), but a few initiatives will be elaborated on to make a point of their potential impact. These recommendations generally emphasized USAF leaders getting involved with promoting change in member's way of thinking about seeking help for mental health care.

One recommendation called for "upgrading professional military education (PME) curricula at all levels of training for both officers and enlisted."[4] Experts are developing the new curriculum so that "information is emphasized which is most relevant for the student's grade and level of responsibility."[5] These additions should be reflected in PME classes in the near future.

Another concern the IPT highlighted was "…that lack of confidentiality prevented members from seeking help during a crisis…"[6] A revision was recommended to Military Law so a military member facing disciplinary action under the Uniform Code of Military Justice (UCMJ) could seek help from mental health providers without fear.[7] This program, called Limited Privilege Suicide Prevention Program (LPSP), allows a member, who is suspected of being a suicide risk, to have some level of confidentiality (that is, protected communications), when talking to a mental health provider. The member is removed from the program when they are no longer at risk.[8]

Another IPT recommendation called for the update of some AFIs. This has led to policies being created, changed, or updated to encourage help seeking behavior. These new AFIs, "…integrate and coordinate overlapping services already provided by other

helping agencies such as family support, family advocacy, chapel, health and wellness centers and mental health", and they, "…develop a standard for USAF critical incident stress debriefings (CISD) or teams to provide care in the aftermath of suicides and other traumatic event."[9]

AFI 44-154, titled *Suicide Prevention and Community Training,* came out March 1997. This AFI "…implements USAF medical operations concerning suicide prevention education and community training."[10] It requires that all USAF personnel "…receive training in general suicide prevention at least on an annual basis…and that all squadron commanders receive training on basic suicide risk factor identification and referral procedures…as part of a new squadron commanders course."[11] The training is designed to de-stigmatize help seeking behavior among USAF personnel, and tailored to specific community-level training requirements. The community training is divided into four levels of training. Level 1 or "Individual" is "Buddy care" training for all non-supervisory personnel, Level 2, "Unit Gatekeepers" is for all supervisors, first shirts, and commanders, Level 3, "Community Gatekeepers" is for all helping base professional except medical personnel, and Level 4, "Medical Professionals" is for all medical personnel.[12]

Another USAF document, AFI 44-153, titled *Critical Incident Stress Management*, came out July 1997. It implements USAF "medical operations establishment of critical incident stress teams (CIST) at all active-duty USAF installations and defines the composition and role of these teams in providing pre-exposure preparation training, defusings and critical incident stress debriefs (CISD)."[13] This AFI defines how:

> …critical incident stress management (CISM) preventative services will be provided to unit and community members before potential traumatic

> events occur, and post-event to help those who have experienced traumatic events. The goal of CISM is to assist those affected by traumatic events to cope with normal stress reaction in an effective manner…[and]…to minimize the impact…and prevent or mitigate permanent disability if possible. CISM services are mandatory for all Class A aircraft mishaps, or conducted by the CIST when exposure to potentially traumatic events is expected. Following Class A aircraft mishaps, USAF personnel may request and be provided up to four one-on-one CISD sessions. If greater than four debriefings sessions are required, either mental health treatment or counseling by the chaplain may be initiated; stress debriefing will be concluded. CISD is not therapy even though mental health and medical providers are part of the team, rather these debriefings are educational in nature. [14]

Another mental health care initiative involves integration. According to Lt. General Roadman, the USAF is "…studying ways to integrate mental health services into primary care clinics, such as, family practice and flight medicine."[15] One such step is the Mental Health & Primary Care Prototype Project.[16] This project is currently documenting what impact placing mental health providers on primary care teams can have. Mental health providers have offices co-located along side family practice physicians, physician assistants, and nurse practitioners in primary care clinics. Under this prototype project, if an active-duty member visits their primary care facility, and is suspected of needing some mental health expertise, the primary care physician can invite the mental health provider into his office while the member is still being treated, or simply ask the member to enter the mental health providers office which is right next door. A separate appointment should not be necessary, and the member would not have to visit the "dreaded mental health ward on the third floor." Under this arrangement the barriers to seeking mental health may be hidden. It is anticipated that mental health care prevention, intervention, and treatment may take place more often, and the percentage of active-duty personnel that go undiagnosed or untreated may decline—medical care should be improved.[17]

According to Maj. Rich Handley, chief of Air Education and Training Command Mental Health and Family Advocacy, all these initiatives, "…create a web linking individuals, supervisors, commanders, first sergeants, the community and the medical professional together. The resulting program, from the IPT's recommendations, is geared toward "…changing the [USAF's] corporate culture." It is designed to "…[de-stigmatize] and encourage help-seeking behavior."[18] Lt. General Roadman believes these steps will "…benefit the USAF in general, reduce the number of suicides, and contribute to the effort of building healthy communities."[19]

Confidentiality

Major Moore also addressed the confidentiality issue. He said, the military has addressed the potential for abuses in confidentiality primarily by means of "informed consent."[20] On reporting to a USAF mental health care clinic, active-duty members are required to sign an informed consent document that specifically outlines the limits of confidentiality for that particular setting. A patient will sign this consent form before treatment begins, or he or she may elect to refuse to sign the consent and leave without treatment. He said there are times the military medical professional is required, by Air Force Instructions (AFIs), to divulge certain information (alcohol rehabilitation status, physical abuse etc.), but often times it is up to the discretion of the care provider on who is told and what amount of detail is shared. He acknowledged the stigma of seeking mental health care exists, but believes it is largely unwarranted. The reality is that the vast majority of clinical cases do not have broad security implications, and a high level of privacy can and will be maintained. He believes, if handled correctly, many active duty

members could seek help, and receive treatment, without any ramification to their career.[21]

Even with informed consent, Lt. General Roadman has recognized the great barrier to active duty member seeking mental health care revolves around the confidentiality issue. For this reason, he said the USAF is currently drafting an AFI to significantly broaden the psychotherapist-patient privilege for active-duty members.[22]

Though the recent initiatives flowing from the efforts of the IPT, and efforts to deal with confidentiality show promise of progress, Lt. General Roadman conceded the stigma around mental health treatment, is still common within the military (reflecting society in general).[23] So what else can the USAF do to encourage help seeking behavior? The next chapter discusses the author's recommendations.

Notes

[1] Pomeroy.
[2] Bailey, Team Hones.
[3] Ibid.
[4] Ibid.
[5] Ibid.
[6] Ibid.
[7] Master Sgt. Anita Bailey, Office of the Surgeon General Public Affairs, "AFI changes for members facing UCMJ action" *Air Force News–News Service*, 13 February, 1997, n.p.; on-line, Internet 15 September 1997, available from http://www.af.mil/cgi-bin/multigate/retrieve?u=z3950r://dtics11:1024/airforce!F5137%3a876611461%3a%28menta10/11/97lth%29;e.
[8] Ibid.
[9] Bailey, Team Hones.
[10] Air Force Instruction (AFI) 44-154, *Suicide Prevention and Community Training*, 1 March, 1997.
[11] Ibid.
[12] Ibid.
[13] Air Force Instruction (AFI) 44-153, *Critical Incident Stress Management*, 1 July 1997.
[14] Ibid.
[15] Roadman, letter.

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[16] Briefing slides, Colonel Skip Moe, et al., USAF Associate Chief of Clinical Psychology, subject: Mental Health & Primary Care Prototype Project, March, 1998.
[17] Ibid.
[18] Bailey, Training Program.
[19] Bailey, AFN Team Hones.
[20] Moore, interview.
[21] Ibid.
[22] Roadman, letter.
[23] Ibid.

Chapter 4

Recommendations

> *Researches have repeatedly demonstrated a vital link between the strength of our social support system and our emotional and physical resilience under severe stress…people in crisis who enjoy contact and support from…professionals in the health-care system—tend…to maintain higher morale…suffer fewer physical symptoms…and live longer lives…*[1]
>
> —Dr. Julius Segal

The USAF medical community has taken great measures to deal with the issues, and they should be commended for their efforts. Still, top USAF leaders admit their efforts have not been totally successful. Chapter Two's summary suggested the issues impacting an active-duty member's willingness to seek help are largely unwarranted. The persistence of these flawed perceptions, however, come from a past era. They are no longer valid in today's society or in the current environment in the USAF. So, what more can the USAF do to encourage help seeking behavior for mental health care?

The care for the mentally ill has changed dramatically in the past few decades. Instead of spending time in hospitals or mental institutions, improvements in treatment methods and the use of drugs now allows many patients to be treated as outpatients.[2] Other methods that may help alleviate the stigma attached to mental illnesses revolve around the knowledge gained through advances in science and treatment. Recent studies have revealed some surprising causes of certain mental illnesses. Once stereotyped as stemming from some sort of mental deficiency, some mental illnesses are now thought or

known to be caused by a wide range of physical conditions. Now there is evidence to suggest that viruses, thyroid diseases, adrenal gland diseases, and brain tumors may trigger certain illnesses.[3] As one would not hesitate to, or be stigmatized for, seeking help for a broken bone these new findings suggest mental illnesses are real and genuine diseases and their treatment should be sought out without shame. Sharing the knowledge from these studies, and educating the population could help shatter the stigma and the fear attached to seeking mental health care.

Getting the word out on new treatments and educating a population to counter the misguided perceptions is not an easy or an instant process. As a line officer on flying status for over twelve years, the author's only education on the issues presented in Chapter Two have come from his own research for this project. The author agrees with the IPT's recommendation of upgrading PME to include suicide prevention education, but would advocate a much broader focus to encompass all relevant mental health issues and not restrict the required training solely to suicide prevention. The program is already underway for the suicide prevention initiative. Expanding its focus would not undermine its original goal of preventing suicides. Quite the contrary, the inclusion of a more generalized mental health focus would compliment the goal of suicide prevention and help alleviate other mental health issues at the same time. By dove-tailing efforts into an existing program, this expansion recommendation would be able to save time, money, and effort. The total health of the USAF would be better served.

The author admits his views on these issues had been shaped by ill conceived perceptions, and lack of training or education, but he believes his is not a unique career path, training background, or perception for a non-medical military person. He has had

his fair share of PME (Officer Training School, Squadron Officer School, and is currently attending Air Command & Staff College). Academics on mental health issues have been a notable omission in PME. None of these military schools have provided the author with any mandatory training on the issues of this research. Therefore, the next recommendation is that academic education on mental health issues should be absolutely mandatory in the future.

Military mental heath care providers have long provided stress management classes to the USAF community but attendance in these classes has not been mandatory. Participation has been optional for active-duty members unless a commander became involved and required an individual to attend, or requested a mass briefing for the squadron or unit. Similarly, at Maxwell Air Force Base, the Air War College (AWC) has an established Wellness program, and the ACSC is in the process of developing a similar program. These programs, though not specifically designed to address the subject of this research, have potential to become great conduits to address some of the issues of this research, and impact cultural change within the USAF. However, participation in the program at AWC is on an elective basis, and the program at ACSC, though still in its infancy, has included optional power-lunch seminars. The author suggests that in addition to making PME academic education mandatory, participation in these type PME programs be made mandatory too. Participation in both academics as well as a "wellness-type" program, would better prepare USAF leaders, enhance their knowledge of mental health issues, and encourage more help seeking behavior among them and their subordinates of the future.

Changing an organization's culture takes time, money and effort, but it is long overdue for the USAF. By adopting an approach taken by a civilian organization the USAF could make getting help more accessible, and more acceptable for the active-duty member. Dr. Lakey Tolbert, medical director of BellSouth Corporation, believes the cultural attitude developed by a business or health care provider can help alleviate the stigma attached to seeking treatment for a mental health problem, and make seeking help an acceptable option.[4] Tolbert sees educating the work force as an answer. By describing the mental health problem as a "stress issue", (that is, the illness is a by-product of the stresses occurring in the work environment, rather than a weakness of the individual), more and more professionals are willing to seek help because the stigma is removed. Tolbert currently sees the older professional holding on to the old stigma, but he finds that for the younger professional the stigma is being removed and they tend to seek help more often.[5]

Likewise, a related approach to these mental health issues has been advocated by military research. Lt. Colonel Peter Detracey, of the Canadian Forces, researched stress and its impact on a flying squadron. He argued, "…it behooved a squadron commander to work hard at drawing the mental health professional into the squadron circle through social education and operations activities."[6] His research acknowledged that many squadron members worry about relating problems to professional help out of fear that their career will be jeopardized. He placed the "onus an organization's leadership [to] develop the rapport [with medical professionals] to ensure that well earned stress is not considered to have career implications."[7]

The AFIs discussed in the last chapter do provide the USAF squadron commander, as well as the individual member, with some tools they can use to draw the mental health provider into their squadron.

These new AFIs, have made "training for general suicide prevention mandatory"[8] for all USAF personnel, and made CISD mandatory (or at least available, depending on the situation) to USAF personnel before, or after a "traumatic event happens on a base or during a deployment."[9] The USAF has acknowledged that "…many types of events have the potential to produce traumatic stress."[10] The benefits from CISM accrue through the CISD. In these debriefs, an active-duty member can receive help and education from mental health care providers without it being considered "treatment."[11] That is, these sessions are essentially "off the books", and the members do not have to fear their jobs may be jeopardized because they sought help. The author points out traumatic events are not limited to events that happen solely on an air base or during a deployments (the events targeted by CISM), that traumatic events frequently occur to members while off duty. These "non-duty" traumatic events that occur in an active-duty member's personal life could often times be predictable and have similar potential to cause traumatic stress and the associated coping difficulties. Does the active-duty members who experiences a traumatic event outside of official USAF duties deserve less opportunity to seek help? The author suggests the benefits from CISM could be expanded beyond just Class A mishaps, to other predictable and recognizable stress events in one's personal life (such as relationship problems, divorce, family deaths, adjusting to relocations etc.). Expanding the CISM benefits would allow an active-duty member who is affected by a traumatic event, other than a Class A mishap or a "duty-event", (that is, an "off-duty"

event), to *also* receive a critical incident stress debriefing and up to four one-on-one sessions from a mental health care provider to help prevent long-term emotional problems. This again could reduce the fear an active-duty member has of seeking help, because these sessions, too, would be "off the books", and the members would not fear their jobs are jeopardized for seeking help. To ensure national interests are not compromised, the details under what specific events or conditions these benefits could be expanded would need to be studied, by military medical professionals and legal specialists. Undoubtedly, there would still be limitations, but expansion to the most predictable and/or common traumatic events may encourage help seeking behavior and provide a healthier workforce, while not jeopardizing the higher needs of the nation or the USAF. Similar to the recommendation to expand education into PME, expanding the benefits of CISM would be able to save time, money, and effort by dove-tailing efforts into an already existing program. Again, the total health of the USAF would be better served.

The military is uniquely different from many other organization in that "issues of national security must be considered in any discussion of the need to balance individual rights against public protection."[12] Under some conditions national security/public protection may supersede the individual's rights. As expressed by Major Moore, "confidentiality" is really a legal term.[13] "Informed consent", regarding the limitations on confidentiality, is what mental health care providers must provide to active-duty members.[14] Currently, informed consent is generally given to members in a written document just prior to treatment at the mental health clinic. However, in the case of a commander-directed evaluation, a member who is referred to a mental health care provider

also has additional rights upon his or her request, to include a right to an attorney (see endnotes source for more details on rights of active duty members).[15] Through the results of an informal survey of his ACSC seminar classmates, the author suggests most non-medical, active-duty members have no idea what rights and privileges are afforded to them under the informed consent policy. The author suggests more specific details in procedures and instructions (like: when in fact, certain information can remain private, what subjects can be discussed without having career impact, etc.), be codified, and then shared with the members so they are educated, and aware of what rights they do and do not enjoy. The privileges and limitations of informed consent should then be taught at all levels of PME. The final recommendation is also related to informed consent. This is the issue of privileged communications.

The USAF is currently drafting an AFI to broaden the psychotherapist-patient privilege for active-duty members. According to Major Moore, the USAF Surgeon General's Office is now spearheading enhanced efforts in response to direction given by the current USAF Chief of Staff, General Michael E. Ryan,. Apparently, General Ryan feels the draft AFI did not go far enough in broadening the privileges between military care providers and active duty members, and has asked the USAF Surgeon General to look into expanding these privileges even further.[16] The author believes the issue of privileged communications should be specifically reviewed and incorporated into this new AFI wherever practicable. The IPT's recommendation of LPSP suggests offering privileged communications enhances a members willingness to seek out help. According to Chaplain (Lt. Col.) Bill Bischoff, the senior wing chaplain at Kelly Air Force Base, chaplains enjoy a level of confidentiality that their USAF medical care providers do not.

He believes, "…[active military members] often do not seek help from military medical facilities because they think it will hurt their career."[17] However, "…everyone who sees a chaplain has 'privileged communications'," meaning their information shared with a chaplain can not be told to a commander, supervisor, family member, or even the police without their consent. Bischoff feels, "…privileged communications is one means to dispel the stigma that surrounds seeking help for personal concerns."[18] Expanding privileged communications wherever practicable would encourage more help seeking behavior. National security interests would still dictate there be some limitations on this privilege, but expanding this privilege, even with limitations, could encourage more help seeking behavior in given situations and thereby improve the total health of the USAF active force.

Notes

[1] Dr. Julius Segal, *WINNING LIFE'S TOUGHEST BATTLES – Roots of Human Resilience* (New York: McGraw-Hill Book Company, 1986), 18.

[2] Fred Alan Wolf, *The Body Quantum: The New Physics of Body, Mind, and Health* (London: MacMillan, 1986), 33-34.

[3] Cool.

[4] Staed.

[5] Ibid.

[6] LTC. Peter Detracey, Canadian Forces, "Stress Fatigue and the Squadron Commander," Research Report no. 82-047, Maxwell AFB, AL: Air War College, 1982.

[7] Ibid.

[8] AFI 44-154.

[9] AFI, 44-153.

[10] Ibid.

[11] Ibid.

[12] Jefferey, 723.

[13] Moore, interview.

[14] Ibid.

[15] Air Force Instruction (AFI) 44-109, *Mental Health & Military Law*, 1 March 1997.

[16] Ibid.

[17] Master Sgt. Dave. Masko, "Chaplains can have key role in preventing suicides." *Air Force News–News Service*, 6 May, 1997, n.p.; on-line, Internet 15 September 1997 Available from http://www.af.mil/cgibin/multigate/retrieve?u=z3950r://dtics11:1024/

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[18] Ibid.

Chapter 5

Conclusion

Mental illness affect people at different rates, and cause a variety of mental problems. The sad part is often times these illnesses are very treatable and even preventable. The impact is obviously felt in the victim's personal lives, but mental health problems also have staggering effects on the US work force in areas of productivity, morale, and absentee rates. Many experts feel one ultimate impact of the stigma is the high number of suicide rates experienced annually in the US. The military is not immune from the problems associated with mental illness. Numerous military studies and leaders involved with the mental health care acknowledge there are several issues impacting a members willingness to seek out care. This research generally points to the conclusion that low awareness levels about mental health issue, and the concerns over confidentiality and career impact have allowed a stigma to persist, and therefore continually prevent military members from seeking help from military health care facilities. The USAF is trying to change the inaccurate perception that seeking help for a mental health issue will automatically harm one's career. Top-level leaders, however, admit the USAF has not been successful at de-stigmatizing the use of mental health care. In these days of shrinking military budgets military leaders can ill afford to lose anyone to preventable or treatable medical conditions that can often times be attributed to well earned stress of the

military life style. The USAF has taken action to address some issues surrounding mental health care. The recommendations in chapter four are further steps the USAF could pursue to encourage help seeking behavior from its active duty members.

Glossary

ACSC	Air Command and Staff College
AFI	Air Force Instruction
CISD	Critical Incident Stress Debrief
CISM	Critical Incident Stress Management
CIST	Critical Incident Stress Team
DOD	Department of Defense
IPT	Integrated Project Team
LPSP	Limited Privilege Suicide Protection
UCMJ	Uniform Code of Military Justice
USAF	United States Air Force

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